PA08-2002: COX-2 INHIBITORS REQUEST

RI MEDICAL ASSISTANCE PROGRAM
PRIOR AUTHORIZATION REQUEST FORM

NOT REQUIRED FOR RECIPIENTS UNDER 21 YEARS OF AGE.

FAX OR MAIL TO:
HERITAGE INFORMATION SYSTEMS
ATTN: RI PRIOR AUTHORIZATION UNIT
PO BOX 25719
RICHMOND VA 23286-8212
FAX # 1-800-390-0109

CLIENT NAME _____ DOB: _____ MEDICAID ID NUMBER: _____

PRESCRIBER NAME: _____ PRESCRIBER DEA #: _____

PRESCRIBER OFFICE ADDRESS: _____

_____

OFFICE PHONE NUMBER ( ) _____- _____

REQUESTER NAME: _____ RN /MD /R.PH / ____

PHONE NUMBER ( ) _____-_____ FAX NUMBER ( )_____-_____

DRUG REQUESTED : _____ STRENGTH_____ QTY / FILL _____

REQUEST TYPE: (CIRCLE ONE) INITIAL / REAUTHORIZATION START DATE: _____

DURATION OF THERAPY: 1 3 6 9 12 MONTHS (CIRCLE ONE) UNITS / RX _____ DOSING FREQUENCY: ____

INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD-9 CODE.

CRITERIA SPECIFICATIONS ARE AVAILABLE BY CALLING **(401) 784-8100** OR AT WEB ADDRESS www.dhs.ri.gov/dhs/heacre/provsvcs/mpharpa.htm

FAMILIAL ADENOMATOUS POLYPOSIS ICD9 CODE **(CELECOXIB ONLY)**

RHEUMATOID ARTHRITIS (RA) ICD9 CODE

MUST HAVE PRESENCE OF AT LEAST GI TOXICITY RISK FACTOR PRESENT OR DOCUMENTED THERAPEUTIC FAILURE OF 1 NONSELECTIVE NSAID (SNSAID)

HAS PATIENT RECEIVED A PRESCRIPTION FOR A NSNSAID IN THE PAST 180 DAYS?	*YES*	/	*NO*
Is the patient 75 years of age or older?	*YES*	/	*NO*
Does the patient have a history of PUD or GI Bleed?	*YES*	/	*NO*
Is the patient concurrently using NSAIDS and corticosteroids?	*YES*	/	*NO*
Is the patient concurrently using NSAIDS and oral anticoagulants?	*YES*	/	*NO*

OSTEOARTHRITIS (OA) ICD9 CODE:

MUST HAVE PRESENCE OF AT LEAST ONE GI TOXICITY RISK FACTOR OR DOCUMENTED THERAPEUTIC FAILURE OF ONE NONSELECTIVE NSAID OR APAP

HAS PATIENT RECEIVED A PRESCRIPTION FOR NSNSAID AND TRIAL OF APAP IN THE PAST 180 DAYS?	*YES*	/	*NO*
Is the patient 75 years of age or older?	*YES*	/	*NO*
Does the patient have a history of PUD or GI Bleed?	*YES*	/	*NO*
Is the patient concurrently using NSAIDS and corticosteroids?	*YES*	/	*NO*
Is the patient concurrently using NSAIDS and oral anticoagulants?	*YES*	/	*NO*

NON RA / OA DIAGNOSIS (*ACUTE PAIN /CHRONIC PAIN*) ICD9 CODE :

MUST HAVE PRESENCE OF AT LEAST GI TOXICITY RISK FACTOR PRESENT OR DOCUMENTED THERAPEUTIC FAILURE OF 1 NONSELECTIVE NSAID (SNSAID)

HAS PATIENT RECEIVED A PRESCRIPTION FOR A NSNSAID IN THE PAST 180 DAYS?	*YES*	/	*NO*
Is the patient 75 years of age or older?	*YES*	/	*NO*
Does the patient have a history of PUD or GI Bleed?	*YES*	/	*NO*
Is the patient concurrently using NSAIDS and corticosteroids?	*YES*	/	*NO*
Is the patient concurrently using NSAIDS and oral anticoagulants?	*YES*	/	*NO*

COMMENTS:

PRESCRIBER SIGNATURE _____ **DATE** _____

By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.

PA # _____ **APPROVED**_____

DENIED _____

PENDING ADDITIONAL INFORMATION_____

DATE /TIME OF RECEIPT _____

DATE/TIME RESPONSE _____

REVIEWER _____

COMMENTS:

RI PRIOR AUTHORIZATION CALL CENTER
FAX NUMBER 1-800-390-0109 *(AVAILABLE 24 HOURS)*
TELEPHONE NUMBER 1-866-420-3874

RI PRIOR AUTHORIZATION - CALL CENTER HOURS
MONDAY – FRIDAY 9:00 AM – 6:00 PM (EST)
SATURDAYS 9:00 AM – 1:00 PM (EST)